MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

PARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1143

-62-003789 STATE FILE NUMBER

AMENDED

FILED FEB 2 1962

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. | SHOULD READ | INSTEAD OF | DATE AMENDED | BY AFFIDAVIT OF | DOCUMENT

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b: 23 days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: St. Johns Hospital
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St. Louis
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 5367 Queens Ave
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First WILLIAM Middle A Last GEARY SR.

4. DATE OF DEATH: Month January Day 24 Year 1962

5. SEX: male

6. COLOR OR RACE: white

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 6/13/1888

9. AGE (last birthday): 73 years
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Teller

10b. KIND OF BUSINESS OR INDUSTRY: Banking

11. BIRTHPLACE (City and state or country): St. Louis, Missouri

12. CITIZEN OF WHAT COUNTRY: U. S. A.

13a. FATHER'S NAME: Patrick Geary

13b. MOTHER'S MAIDEN NAME: Mary Reardon

14. NAME OF HUSBAND OR WIFE: Mary Geary

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.

17. INFORMANT Address: Mary Geary - 5367 Queens

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY:)

IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: Hours

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b): Mixed Infection

DUE TO (c): Chronic brain Syndrome

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 491+

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from Aug 1955 to Jan 24 '62 and last saw her/him alive on Jan 24 '62

Death occurred at 10 PM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): R. H. Diessner MD

22b. ADDRESS: Northland Med Bldg

22c. DATE SIGNED: 1-25-62

23a. BURIAL, CREMATION, REMOVAL (Specify): burial

23b. DATE: Jan 27, 1962

23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery

23d. LOCATION (City, town, or county) (State): St. Louis Missouri

24. FUNERAL DIRECTOR ADDRESS: BUCHHOLZ MORTUARY-5967 W. Florissant Ave

25. DATE RECD. BY LOCAL REG.: JAN 26 1962

26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____, Student Embalmer No._____ working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Ralph G. Finders

Licensed Embalmer No. 4275

P. O. Address St Louis Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.